

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Arbor Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 North Church Street Lodi, CA 95240	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50925</p> <p>Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) received care in accordance with professional standards of practice when:</p> <ol style="list-style-type: none"> 1. Resident 1's blood pressure (BP - the measurement of the pressure in the arteries when the heart contracts and pumps blood through the body) medication (Losartan) was administered without parameters (measurable factors or specific values that are used to assess a resident's health or the effectiveness of a treatment) listed on the order that would have indicated when to not administer the medication, and the order was not clarified with the medical doctor (MD) to not administer the medication if the BP reading or heart rate was too low (a measure of how fast the heart is pumping blood throughout the body); and, 2. Resident 1 had high blood pressure readings on 3/10/25 of 173/56 during the morning shift and 168/60 during the night shift (normal BP reading is 120/80), and the MD was not notified. <p>These failures could have resulted in Resident 1 inappropriately receiving BP medication and the potential for worsening of the blood pressure condition which could lead to complications and harm such as a heart attack (when an artery that sends blood and oxygen to the heart is blocked) or stroke (occurs when the blood flow to the brain is suddenly interrupted, either by a blockage or a burst blood vessel).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 1's medical record titled, ADMISSION RECORD, indicated Resident 1 was admitted to the facility with diagnoses that included hypertension (a condition with high blood pressure) and type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing). <p>During a concurrent interview and record review on 4/9/25, at 1:15 p.m., with Licensed Nurse (LN) 1, LN 1 stated Resident 1 was on BP medication Losartan 50 mg (milligram - unit of measurement) once daily in the morning.</p> <p>During a concurrent interview and record review on 4/9/25, at 1:58 p.m., with LN 2, LN 2 verified Resident 1 had hypertension and diabetes.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Order Summary Report, with an order dated 3/6/25, indicated .Losartan Potassium Oral Tablet 50 mg (Losartan Potassium) Give 1 tablet by mouth in the morning for hypertension .</p> <p>A review of Resident 1's Medication Administration Record, for the month of March 2025, indicated the medication Losartan Potassium oral tablet 50 mg was administered to Resident 1 from 3/7/25 to 3/18/25.</p> <p>During a concurrent record review and interview on 4/9/25, at 5:04 p.m., with LN 3, LN 3 confirmed Resident 1 was on BP medication Losartan 50 mg once daily in the morning. LN 3 stated he was not sure if it was required for the BP medication orders to have parameters listed in the order at this facility. LN 3 verified Resident 1's Losartan 50 mg medication order did not have parameters noted. LN 3 stated the way he was trained when entering the BP medication orders in the electronic health record was to include the parameters in the order. LN 3 stated the BP medication parameters usually indicated to hold medication if the systolic blood pressure (SBP - the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood) was less than 100 or if the heart rate was less than 60 beats per minute. LN 3 stated it was important to have the BP medication parameters in place to make sure the nurses checked Resident 1's vitals to see if the medication should have been given. LN 3 further stated that it was also important to verify with the MD about the BP order parameters.</p> <p>During a concurrent interview and record review on 4/9/25, at 5:20 p.m., with the Director of Nursing (DON), the DON acknowledged Resident 1 had an active BP medication order for Losartan 50 mg once daily without parameters in place. The DON stated BP medication orders usually had parameters listed in the order but sometimes the ordering MD did not specify parameters, so it was her expectation for the nurse to have verified the order with the doctor. The DON further stated it was also her expectation that it would be good practice to have parameters set in the BP medication orders and not leave it up to the nurse who gave the medication. The DON stated it would have been best for the nurses to have notified the MD for clarification and to have the medication parameters in the order. The DON further stated the risk of not having BP medication parameters could have impacted Resident 1 when taking the medication since the nurse might not think to check the BP first. The DON gave an example of an instance if the resident's BP was low, and the nurse gave the BP medication without checking the BP. The DON stated the potential concern was that Resident 1 could have experienced hypotension a (medical condition characterized by low blood pressure).</p> <p>During an interview on 4/10/25, at 12:19 p.m., with the MD, the MD stated Resident 1's BP was well controlled and verified she was on BP medication Losartan. The MD further stated general parameters for BP medications should have been in place and the nursing staff usually called him to verify these types of orders. The MD stated that typically anything below 100 SBP; the nurses needed to call him to report the value. The MD further stated he did not recall any clarification from facility staff about Resident 1's BP medication order. The MD stated it was his expectation for the nursing staff to have verified BP medication orders with him. The MD explained the purpose of having BP parameters was to avoid undue effects like hypotension (low blood pressure), intolerant hypokalemia (the body can't tolerate or function properly when potassium levels are too low) and acute kidney injury (a temporary malfunction of the kidneys, which usually filter waste and extra fluid from the blood).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a concurrent interview and record review on 4/9/25, at 1:15 p.m., with LN 1, LN 1 reviewed Resident 1's BP history for the month of March 2025 and verified the systolic blood pressure readings were mostly in the 130 to 140's for the SBP.</p> <p>A review of Resident 1's vitals summary report for March 2025, indicated two high blood pressure readings of 173/56 on 3/10/25 at 9:53 a.m., and 168/60 on 3/10/25 at 9:52 p.m.</p> <p>During a concurrent record review and interview on 4/9/25, at 5:04 p.m., with LN 3, LN 3 reviewed Resident 1's BP readings for the month of March 2025 and verified high BP readings of 173/56 on 3/10/25 at 9:53 a.m. and 168/60 on the same day at 9:52 p.m. during the evening shift. LN 3 stated he would have notified the doctor if he was the nurse taking care of Resident 1 at the time of the high blood pressure readings that were taken on 3/10/25. LN 3 further stated that he would have reviewed Resident 1's BP readings for trends and confirmed that Resident 1's baseline was around 130 to 140 SBP. LN 3 stated the nurse should have notified the doctor about Resident 1's high BP readings on 3/10/25 since they were done separately in the morning and in the evening shift, and the readings were still out of the normal range. LN 3 further stated it was important to notify the MD for high blood pressure readings because that could have indicated complications with the heart.</p> <p>During a concurrent interview and record review on 4/9/25, at 5:20 p.m., with the DON, the DON reviewed Resident 1's BP readings for the month of March 2025, and verified the highest BP reading of 173/56 on 3/10/25 during the day shift and 168/60 during the evening shift. The DON stated her expectation was for staff, especially with a BP reading of 173/56, to have confirmed an acute (a sudden onset and short duration) reading. The DON stated it was her expectation for staff to have rechecked the BP and should have documented if rechecks were done. The DON further stated it was important to notify the MD for any abnormal high BP readings because the BP could have continued to climb and Resident 1 could have a stroke, heart attack and multiple possible complications.</p> <p>During an interview on 4/10/25, at 12:19 p.m., with the MD, the MD stated Resident 1's BP readings of 173/56 and 168/60 on 3/10/25 were elevated BP readings. The MD stated that if the facility called him during the time of these BP readings, then he would have instructed them to check the BP reading within one hour and then see how the BP readings went from there. The MD further stated he did not remember being called by facility staff about these BP readings. The MD stated that the facility staff should have notified him for any elevated BP. The MD further stated that if Resident 1's BP was at least 180, he would have considered acute hypertensive crisis (a sudden, severe increase in blood pressure that can cause serious damage to organs, especially the brain, heart, and kidneys) and then consider a stroke assessment. The MD stated if Resident 1 had multiple elevated BP readings in one day, he would have considered long term management, but the staff still should have notified him. The MD further stated a change in condition could be acute or chronic (a condition that continues over an extended period of time) depending on the presentation of the symptoms. The MD stated the facility needed to do a better job in educating the staff in reporting abnormal or elevated BP readings to the MD. The MD stated if a resident was having a hypertensive emergency, the resident would be at risk for organ damage, pulmonary edema (a condition where excessive fluid accumulates in the lungs, making it difficult to breathe), intracranial hemorrhage (bleeding within the skull, either inside the brain tissue or in the spaces around it) and encephalopathy (a problem with brain function, leading to changes in thinking, feeling, and acting).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of facility's document titled, Change of Condition, dated year 2016, indicated .BASIC RESPONSIBILITY .Licensed Nurse .PURPOSE .To appropriately assess, document and communicate changes of condition including diagnostic results to the primary care provider. To provide treatment and services to address changes in accordance with resident needs .ASSESSMENT GUIDELINES .May include, but not limited to: vital signs .PROCEDURE .If the change in condition does not require an immediate 911 transfer the following steps may be followed .1. Document assessment findings and communications as soon as practical .2. Notify physician and responsible party of assessment finding .</p>		